DCH/VOL-500 (10/06)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30192
Lansing, Michigan 48909
(517) 335-0918
www.michigan.gov/healthlicense

VOLUNTEER LICENSURE INSTRUCTIONS FOR RETIRED PHYSICIANS AND PODIATRISTS

Authority: P.A. 368 of 1978, as amended
This form is for information only.

NOTE: It is your responsibility to have all required documentation sent to the Bureau of Health Professions. Questions regarding your application can be directed to the Bureau of Health Professions at (517) 335-0918 four weeks after the date you sent the application. Please allow 6-8 weeks processing time. You are advised that an application for licensure **WILL NOT BE CONSIDERED UNTIL ALL REQUIRED DOCUMENTATION IS SUBMITTED.**

INSTRUCTIONS: The volunteer license is available only for retired physicians or podiatrists who were previously licensed to practice in Michigan, but who no longer have a current, active Michigan professional license. Also, this license may be obtained only for the purpose of donating treatment and care in Michigan to indigent and needy individuals or in medically underserved areas. In order to obtain this license, the applicant must submit:

1. A completed application for a volunteer license, and controlled substance license if desired, on the enclosed forms. There is no fee for the volunteer license. The fee for a controlled substance license is $235.00.

2. A completed Volunteer License Affidavit (included in the application packet).

3. If you have ever held a permanent license in another state, official verification of your license must be received in this office directly from the other state(s). You may use the Verification Form that is attached to this application. Most states charge a fee for providing license verification.

4. If your license to practice has been lapsed for three or more years, you must submit documentation verifying the completion of 90 continuing education hours in board-approved activities within the last three years.

GENERAL INFORMATION

1. NAME AND/OR ADDRESS CHANGES: If your name and/or address changes please notify the Bureau of Health Professions in writing. To change a name or address, you can download the Data Change/Duplicate License Request Form from our website www.michigan.gov/healthlicense and fax it to (517) 373-2179 or mail the form to Bureau of Health Professions, PO Box 30670, Lansing, MI 48909. Telephone calls are NOT accepted for these changes. You may also make address changes electronically at www.michigan.gov/mylicense.

2. **NOTE:** If you have ever been licensed in another state and you have a current disciplinary sanction on that license, (even if the license is inactive), you are **not** eligible for licensure in Michigan according to the Public Health Code, PA 368, as amended, Section 222.16174 (3). Sanctions include probation, limitation, suspension, revocation or fine. Upon resolution of the sanction and verification that the license is active with no disciplinary action in effect, you can proceed with the filing of an application for a Michigan license or registration.

YOUR VOLUNTEER LICENSE WILL BE VALID FOR A THREE YEAR-PERIOD AND WILL EXPIRE ON THE FOLLOWING DATES:

MEDICINE – JANUARY 31 OSTEOPATHIC MEDICINE – DEC 31 PODIATRIC MEDICINE – MARCH 1

NOTE: Licensees holding volunteer licenses must comply with all provisions of full licensure, including continuing education. Licensees will be required to reaffirm at the time of renewal that they are not receiving any payment or compensation for any medical care services provided under the volunteer license.

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Board Use Only
License Number
Date of Licensure

APPLICATION FOR VOLUNTEER LICENSURE

Authority: Public Act 368 of 1978, as amended.
If this form is not completed, a license will not be issued

A controlled substance license is required for every person who prescribes, manufactures, distributes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended. Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration, 431 Howard Street, Detroit, MI 48226 (Telephone 1-800-882-9539).

Type or Print Only

I AM APPLYING FOR THE FOLLOWING (Check One Only):

- ☐ **Volunteer License for a Medical Doctor:** **No Fee**
- ☐ **Volunteer License for a Osteopathic Physician:** **No Fee**
- ☐ **Volunteer License for a Podiatric Medical Physician & Surgeon:** **No Fee**

If you need a Controlled Substance license, please complete the attached Controlled Substance application form and submit it with the 3-year fee of $235.00.

First Name	Middle Name	Last Name
U.S. Social Security Number	Date of Birth	Daytime Phone Number ( )
Street Address		
City	State	E-Mail Address
All Previous Names and/or Birth Name Used (if applicable)		ZIP Code
Have you ever held a health professional license in Michigan? ☐ Yes ☐ No		Michigan Permanent I.D. Number and Expiration Date

Check the appropriate answer to each of the following questions. NOTE: Attach a detailed explanation for any Yes answer you check.

1. Have you ever been convicted of a felony?	☐ Yes	☐ No
2. Have you ever been convicted of a misdemeanor punishable by imprisonment for a maximum of 2 years?	☐ Yes	☐ No
3. Have you ever been convicted of a misdemeanor involving the illegal delivery, possession, or use of alcohol or a controlled substance (including motor vehicle violations)?	☐ Yes	☐ No
4. Have you been treated for substance abuse in the past 2 years?	☐ Yes	☐ No
5. Have you had 3 or more malpractice settlements, awards, or judgments in any consecutive 5 year period?	☐ Yes	☐ No
6. Have you had one or more malpractice settlements, awards, or judgments totaling $200,000 or more in any consecutive 5 year period?	☐ Yes	☐ No
7. Have you ever had a federal or state health professional or controlled substance license revoked, suspended, or otherwise disciplined; been denied a license; or currently have disciplinary action pending against you?	☐ Yes	☐ No
8. Have you ever been denied the privilege of taking an examination by any state medical board?	☐ Yes	☐ No

Name

9. What is the status of your physician license?

☐ Expired (lapsed) ☐ Active ☐ Other (please specify) _____

10. Have you ever been censured, or requested to withdraw from a health care facility's staff or had your health care facility staff privilege involuntarily modified? ☐ Yes ☐ No

11. Do you hold or have you ever held a permanent medical license in any state, U.S. Territory or Canadian Province? If yes, list the state(s) U.S. Territory or Province in which you hold or have held a medicine license, the license or registration number, the date issued, and how the license was obtained. DO NOT LIST TEMPORARY LICENSES. **You must have each licensing agency verify licensure directly to this board office. (Attach additional sheets, if necessary)** ☐ Yes ☐ No

State, U.S. Territory or Province	License Number	Date of Issue	How obtained (Endorsement or examination)

CERTIFICATION

I understand that it is the policy of this agency to secure a criminal conviction history as part of the pre-licensure screening process. I authorize this agency to use the information provided in this application to obtain a criminal conviction history file search from the Central Records Division of the Michigan Department of State Police or other law enforcement or judicial record-keeping organization.

I further consent to the release of information to this agency regarding any disciplinary investigations conducted by a similar licensure, registration, or specialty certification board of this or any other state, of the United States military, of the federal government, or of another country.

The statements in this application are true and correct. I have not withheld information that might affect the decision to be made on this application. In signing this application, I am aware that a false statement or dishonest answer may be grounds for denial of my application or revocation of my license and that such misrepresentation is punishable by law.

Signature of Applicant	Date

DCH/VOL-020 (10/06)

Michigan Department of Community Health
Bureau of Health Professions
P.O. Box 30670
Lansing, Michigan 48909
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www.michigan.gov/healthlicense

VOLUNTEER LICENSE AFFIDAVIT

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

Please complete this form and return it to the address above. Processing of your application is being delayed until this information is received.

First Name	Middle Name	Last Name
Street Address		Telephone Number
City	State	Zip Code
US Social Security Number	Date of Birth	Michigan Permanent I.D./License Number

Board:

- ☐ Medicine
- ☐ Osteopathic Medicine
- ☐ Podiatric Medicine

CERTIFICATION

I confirm that I allowed my license to practice to expire and that I am now applying for a volunteer license. This license will enable me to donate my expertise for the medical care and treatment of the indigent and needy in this state or for medical care and treatment in medically under-served areas of this state.

I affirm that I will not receive any payment or compensation, either direct or indirect, or have the expectation of any payment or compensation for any medical care services provided by me under the volunteer license.

I understand that I will be subject to all the provisions of the Public Health Code regarding licensure including the continuing education requirement if I am granted a volunteer license.

Signature of Applicant	Date

Michigan Department of Community Health
Board of Pharmacy
P.O. Box 30670
Lansing, MI 48909
(517) 335-0918
www.michigan.gov/healthlicense

DCH/LPH-090 (09/06)

Board Use Only
License Number
Date of Licensure

CONTROLLED SUBSTANCE LICENSE APPLICATION

Authority: Public Act 368 of 1978, as amended
If this form is not completed, a license will not be issued.

A controlled substance license is required for every person who manufacturers, distributes, prescribes, or dispenses any controlled substance in Michigan as described in Article 7 of Public Act 368 of 1978, as amended.

A separate controlled substance license is required for each business location from which you manufacture, distribute, or dispense controlled substances. If you only prescribe controlled substances at more than one location, you only need one controlled substance license.

Information on obtaining a Federal controlled substance license may be obtained by contacting the Regional Branch, Drug Enforcement Administration 431 Howard Street, Detroit, Michigan 48226 (telephone: 800-882-9539). The Michigan Board of Pharmacy is unable to answer questions about the federal licensing process.

Type or Print Only

INSTRUCTIONS

1. CONTROLLED SUBSTANCE FEE: Initial (first time) professional license or relicensure of your professional license - $85.00.
   If you already hold a professional license and your professional license expires in:

   0-12 months the fee is $85.00 (13757) **13-24 months the fee is $160.00 (23757)** **25-36 months the fee is $235.00 (33757)**

2. **M.D./D.O. Applicants: This application may not be used for physician methadone programs. Please request an application for the Physician Methadone Program.**

3. **Allow up to six weeks for your paper license to arrive.**

Your check or money order drawn on a U.S financial institution and made payable to the **STATE OF MICHIGAN** must accompany this application. **DO NOT SEND CASH**. Fees are deposited upon receipt and can only be refunded under refund rules promulgated by the Department.

First Name	Middle Name	Last Name

Street	Telephone Number

City	State	ZIP Code

TYPE OF PROFESSIONAL LICENSE

(Please Check One):

	Regular		Educ. Lmt.		Volunteer
☐ 29 - 01 D.D.S. 71-5315	☐	or	☐		
☐ 59 - 01 D.P.M. 71-5315	☐	or	☐	or	☐
☐ 69 - 01 D.V.M. 71-5315	☐	or	☐		
☐ 43 - 01 M.D. 71-5315	☐	or	☐	or	☐
☐ 51 - 01 D.O. 71-5315	☐	or	☐	or	☐
☐ 49 - 01 O.D. 71-5330	☐				
☐ 53 - 01 Pharmacy Store 71-5301	☐				
☐ 53 - 02 R.Ph. 71-5302	☐				
☐ 53 - 06 Manuf./Wholesaler 71-5306	☐				

STATUS:

1. **Have you ever had any health professional license limited, suspended, revoked, denied, or surrendered?**
   ☐ **Yes** ☐ **No**
   If Yes, please explain on separate sheet.
2. **Is your current professional license limited as a result of Board disciplinary action?**
   ☐ **Yes** ☐ **No**

Michigan Permanent I.D. Number (as shown on your pocket card)	
Expiration Date of License	Social Security Number

I am applying for a controlled substance license in Michigan and certify that the statements and information above are true.

Signature	Date

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the American's with Disabilities Act, you may make your needs known to this agency.

DCH/HLD-001 (02/06)

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VERIFICATION OF LICENSURE OR REGISTRATION IN ANOTHER STATE

Authority: Public Act 368 of 1978, as amended.

PART I: To be completed by the applicant and forwarded to the appropriate State Licensing Board for completion.

Check the profession for which you are requesting verification.

☐ Audiology	☐ Medicine	☐ Osteopathy	☐ Psychology
☐ Chiropractic	☐ Nursing	☐ Pharmacy	☐ Respiratory Therapy
☐ Counseling	☐ Nursing Home Adm.	☐ Physical Therapy	☐ Sanitarians
☐ Dentistry	☐ Occupational Therapy	☐ Physician's Assistants	☐ Social Work
☐ Marriage & Family Therapy	☐ Optometry	☐ Podiatry	☐ Veterinary

First Name	Middle Name	Last Name
Previous Names Used	**Date of Birth**	**U. S. Social Security Number**
State Board	**License Number**	**Date of Issue**

The applicant listed above has applied for licensure in Michigan and has indicated licensure in your State.
Please complete Part II of this form and return it to the appropriate Michigan Board at the address shown above.

PART II: To be completed by the State Licensing Board.

Type of License:	Original Issue Date	Expiration Date

Basis for Issuance of License:

☐ Examination - Please indicate type of exam (National, Regional, State, etc.) _____

☐ Endorsement - Please indicate name of state _____

License Status	Has the applicant incurred any formal or informal actions in your State?
☐ Current ☐ Lapsed ☐ Inactive	☐ No ☐ Yes - If Yes, Please attach certified copies of any actions.

Are formal or informal actions pending?	Has the applicant's license ever been limited, denied, surrendered, reprimanded, suspended or revoked?
☐ No ☐ Yes	☐ No ☐ Yes

CERTIFICATION

I hereby verify, to the best of my knowledge, the information above is true to the records of this Board.

_____ _____
Signature **Date**

_____
Type or Print Name

(S E A L)

_____
Title

_____
Full Name of Licensing Board

The Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability or political beliefs. If you need assistance with reading, writing, hearing, etc., under the Americans with Disabilities Act, you may make your needs known to this agency.